

Correspondence

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TO THE EDITOR, *Genitourinary Medicine*

Bone invasion in secondary syphilis

Sir,
We read with great interest the article of Ollé-Goig *et al* (*Genitourin Med* 1988; 64:198-201), which described two cases of bone invasion in patients with secondary syphilis and lamented the scarcity of similar published reports.

In 1985 we published a report of two cases of periostitis in secondary syphilis (*J Roy Soc Med* 1985;78:721-4), and at that time we could only find three other papers with similar findings.¹⁻³ Both our patients had secondary syphilis with periostitis, but only minimal radiological changes were seen in case 1 and none in case 2, in contrast to the fairly florid changes found in congenital or late syphilis.

The diagnosis of periostitis could be missed in secondary syphilis for several reasons: the bony lesions may be asymptomatic; early syphilitic periostitis and osteomyelitis seldom produce radiological changes;⁴ and headaches caused by skeletal lesions may be attributed to meningeal involvement. In our patients the diagnosis of periostitis would have been missed if bone scintigraphy had not been carried out; and we think that a higher incidence of bony lesions will be found if this technique is used as a routine investigation in secondary syphilis.

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References

- 1 Hansen K, Hvid-Jacobsen K, Lindewald H, Sørensen PS, Weismann K. Bone lesions in early syphilis detected by bone scintigraphy. *British Journal of Venereal Diseases* 1984;60:265-8.
- 2 Siegel D, Hirschman SZ. Syphilitic osteomyelitis with diffusely abnormal bone scan. *Mt Sinai J Med* 1979;46:320-3.
- 3 Tight RR, Warner JF. Skeletal involvement in secondary syphilis detected by bone scanning. *JAMA* 1976;235:2326.
- 4 Roy RB, Laird SM. Acute periostitis in early acquired syphilis. *British Journal of Venereal Diseases* 1973;49:555.

TO THE EDITOR, *Genitourinary Medicine*

Rising incidence of penicillinase producing *Neisseria gonorrhoeae* in Paris, France, in 1985-7

Sir,
Penicillinase producing *Neisseria gonorrhoeae* (PPNG) strains were first isolated in 1976,¹ but were not described in France until 1979.² To evaluate the prevalence of PPNG strains in patients attending the sexually transmitted diseases (STD) centre of Hôpital Saint-Louis (Paris, France), we conducted a prospective study of *N gonorrhoeae* isolates from all men presenting with uncomplicated gonococcal urethritis in April and May of three consecutive years. We recovered 213 strains in 1985, 216 in 1986, and 114 in those two months of 1987 and studied them for β lactamase production by a chromogenic cephalosporin test (Cefinase,* Bio-Mérieux). The incidence of PPNG strains rose from 9/213 (4.2%) in 1985 to 22/216 (10.2%) in 1986³ and 18/114 (15.8%) in 1987. All three groups of men were statistically comparable (χ^2 test) for age, ethnic group, profession, marital status, sexual orientation, and place and mode of infection. The small number of patients with gonococcal urethritis who attended our centre in 1987 reflects the generally diminishing incidence of gonorrhoea in Paris since 1986, probably because of protective measures against infection with human immunodeficiency virus (HIV).

All 18 patients with urethritis caused by PPNG strains in 1987 had been infected in Paris, half of them (9/18) by female prostitutes. The rising incidence of PPNG strains in our centre is of particular concern. Although our population is poor and urban and does not truly reflect the incidence of PPNG strains in the whole country, a spread of PPNG strains is predictable, as it has already occurred in New York city (Sood R, *et al*, unpublished observation).

Close epidemiological studies of isolates of *N gonorrhoeae* are recommended and from now on, penicillin as first line treatment for gonococcal urethritis should be abandoned in Paris.

Yours faithfully,
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References

- 1 Phillips I. Beta-lactamase producing penicillin resistant gonococcus. *Lancet* 1976;ii: 1379-82.
- 2 Thabaut A, Durosoir JL, Saliou P, *et al*. Premier isolement en France d'une souche de *Neisseria gonorrhoeae* productrice de pénicillinase. *La Nouvelle Presse Médicale* 1979;8:2903-4.
- 3 Morel P, Lassau F, Grandry B, Casin I. Augmentation de la fréquence des uréthrites masculines à *Neisseria gonorrhoeae* sécrétant de pénicillinase à Paris. *Presse Méd* 1987;16:634.

TO THE EDITOR, *Genitourinary Medicine*

Non-radioactive DNA probe to identify *Neisseria gonorrhoeae*

Sir,
We have recently evaluated a non-radioactive DNA probe (Ortho Diagnostic Systems Limited, High Wycombe, Bucks) developed as a culture confirmation test for definitively identifying *Neisseria gonorrhoeae*. The organisms were inoculated on to a membrane, lysed, and neutralised. The probe was then applied, and the membrane was treated with a conjugate and washed. A chromogen substrate was added for a specified time, and the reaction then stopped in a solution of 1% sodium azide. A positive result was indicated by the development of a blue colour.

We tested a range of *Neisseria* spp and related organisms, including stock strains and isolates obtained on primary culture from clinical specimens. The reactions were read blind by three workers and graded as being negative, weakly positive, positive, or strongly positive according to the intensity of the colour. Appropriate control organisms were included. As shown in the table, 30 strains of *N gonorrhoeae* were examined. Most (27) of these gave a positive result. Of the three isolates that gave a negative result, two were negative on initial testing (one of